

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04766

CERTIFICATE OF DEATH

Reg. Dist. No.....

94

1. PLACE OF DEATH- COUNTY <i>Cecil</i>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Maryland</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>North East Boro</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>North East Rural</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <i>GONELIA</i>	(Middle) <i>VAILL</i>	(Last) <i>ABRAMS</i>
4. DATE OF DEATH	(Month) <i>May</i>	(Day) <i>3</i>	(Year) <i>1951</i>
5. SEX	6. COLOR OR RACE <i>Female</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>July 3 1876</i>
9. AGE last birthday <i>74</i>	10. BIRTHPLACE, (State or foreign country) <i>Cecil Co. Md.</i>	11. BIRTHPLACE, (State or foreign country) <i>Cecil Co. Md.</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	14. MOTHER'S MAIDEN NAME <i>Hanna Guthrie</i>	13. FATHER'S NAME <i>Edward Smith</i>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT AND ADDRESS <i>Ernest Abrams North East Md</i>	18. MEDICAL CERTIFICATION <i>Arteriosclerotic Cerebrovascular disease</i>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause <i>Arteriosclerotic Cerebrovascular disease</i>	Antecedent cause(s) <i>Unknown</i>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>Unknown</i>	(b) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at m. Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <i>4:40 p.m.</i>	
22. I hereby certify that I attended the deceased from <i>April 29, 1951</i> , to <i>May 3, 1951</i> , that I last saw the deceased alive on <i>April 29, 1951</i> , and that death occurred at <i>4:40 p.m.</i> , from the causes and on the date stated above. SIGNATURE <i>S. Ralph Andrew Jr.</i> (Degree or title) <i>M.D.</i> ADDRESS <i>Elkton, Md.</i> DATE SIGNED <i>May 4, 1951</i>			
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE <i>May 6 1951</i>	NAME OF CEMETERY OR CREMATORIAL <i>Bayview</i>	LOCATION (City, town, or county) (State) <i>near North East Md</i>
DATE REC'D BY LOCAL REG. <i>May 3-51</i>	REGISTRAR'S SIGNATURE <i>Sarah E. Rothermel</i>	24. FUNERAL DIRECTOR <i>J. E. Tyson Rising Sun, Md.</i>	ADDRESS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04767

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH- COUNTY		Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE		Virginia COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		Perry Point LENGTH OF STAY (in this place) 14 mo. 5 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		Charlottesville, Va. (If rural, give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Veterans Administration Hospital		STREET ADDRESS		1114 East High Street	
3. NAME OF DECEASED (Type or Print)		(First) JOHN	(Middle) H.	(Last) AMOS	4. DATE OF DEATH	May 27	19 51
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. If under 1 year Months	11. If under 24 hrs. Days	12. If under 24 hrs. Hours
Male	White	Single	9-15-1888	62 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Unknown		None		Virginia		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME					
Charles Thompson Amos		Nannie Virginia Richardson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS			
		None		Hospital Records, VAH, Perry Point, Md.			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
002X							
Immediate cause		(a) Pulmonary tuberculosis, bilateral, far advanced					
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(b) Arteriosclerosis, generalized					
		(c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21. ACCIDENT SUICIDE HOMICIDE		(Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)		(COUNTY)
				INJURY			(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		m.		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		
VA							
22. I hereby certify that I attended the deceased from 3-22, 1950, to May 27, 1951, that I last saw the deceased alive on 10:00, and that death occurred at 6:50 p.m., from the causes and on the date stated above.							
SIGNATURE (Degree or title) ADDRESS DATE SIGNED							
W. OPIE, M.D., ACTING Chief Professional Services, VAH, Perry Point, Md. 5-28-51							
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIAL		LOCATION (City, town, or county) (State)	
Removal		5-28-51		Arlington National		Arlington, Va.	
DATE REC'D BY LOCAL REG.		REG. DATE REC'D BY LOCAL REG.		REG. DATE REC'D BY LOCAL REG.		REG. DATE REC'D BY LOCAL REG.	
May 28 1951		Ida M. Daugherty		Pennington & Son		Pennington & Son, Gavre de Grace, Md.	
act Reg. 11							

RECEIVED
FEB 2 1951
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04768

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH COUNTY		Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE		District of Columbia COUNTY		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		Perry Point		LENGTH OF STAY (in this place) 6 mo. 14 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Veterans Administration Hospital		STREET ADDRESS		(If rural, give location) 941 - 9th Street, N.W.		
3. NAME OF DECEASED (Type or Print)		(First) KENNETH	(Middle) B.	(Last) ARMSTRONG	4. DATE OF DEATH	(Month) May	(Day) 16	(Year) 1951
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. If under 1 year Months	11. If under 24 hrs. Days	12. If under 24 hrs. Hours	13. If under Min.
Male	White	MARRIED	9-30-1906	44 yrs.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber			10b. KIND OF BUSINESS OR INDUSTRY Self-employed			11. BIRTHPLACE (State or foreign country) New Jersey		
13. FATHER'S NAME Harry Armstrong - Deceased			14. MOTHER'S MAIDEN NAME Mary Lindaburg - Deceased			12. CITIZEN OF WHAT COUNTRY? USA		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW II			16. SOCIAL SECURITY NO. 144-14-2447			17. INFORMANT AND ADDRESS Hospital Records, VAH, Perry Point, Md.		
18. MEDICAL CERTIFICATION								
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH								
153X Immediate cause Pneumonia, Bronchial, bilateral Antecedent cause(s) due to 462 Diseases or conditions, if any, (b) Carcinoma of large bowel with metastasis to giving rise to the above cause stating the underlying cause last the stomach, liver and lymph nodes (c)								
7 days								
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.								
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION						
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>								
21. ACCIDENT SUICIDE HOMICIDE		(Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year)		(Hour)		INJURY OCCURRED While at Work <input type="checkbox"/> Not While Work <input type="checkbox"/> m. At work <input type="checkbox"/>		HOW DID INJURY OCCUR?		
VA 22. I hereby certify that I attended the deceased from Nov. 2, 1950, to May 16, 1951, that I last saw the deceased and that death occurred at 7:00 a.m., from the causes and on the date stated above. SIGNATURE W. Oppler (Degree or title) ADDRESS DATE SIGNED								
W. OPPLER, M.D. Acting Chief, Professional Services, VAH, Perry Point, Md. 5-17-51								
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORIAL		LOCATION (City, town, or county)		(State)
Removal		5-17-51		Arlington National		Arlington, Va.		
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS		
May 17, 1951		Ida M. Daugherty acting Reg.		Pennington & Son		Havre de Grace, Md.		



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04769

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH COUNTY Cecil		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) Elkton		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Elkton, STREET ADDRESS 200 E. Main St.	
LENGTH OF STAY (In this place) Life		(If rural give location) 200 E. Main St.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 200 E. Main St.			
3. NAME OF DECEASED (Type or Print) Eloise	(First) (Middle) W.	(Last) Ash	4. DATE OF DEATH May 30 1951
5. SEX F	6. COLOR OR RACE WH	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Mar. 11, 1872
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY At Home	9. AGE last birthday 79 yrs.
11. BIRTHPLACE (State or foreign country) Fredericktown, Md.		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME Benjamin F. Walmsley		14. MOTHER'S MAIDEN NAME Frances W. Briscoe	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Reynolds Ash Elkton, Md.		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause 421.4	(a) Uremia 1 day		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause 131a	(b) Chronic interstitial nephritis 1 year		
stating the underlying cause last	(c) Chronic endocarditis 5 years		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at m. Work	HOW DID INJURY OCCUR? Not While At work
22. I hereby certify that I attended the deceased from 1925, to May 30, 1951, that I last saw the deceased alive on May 30, 1951, and that death occurred at 9:30 A.M., from the causes and on the date stated above. SIGNATURE H. W. Pippin & Son ADDRESS Elkton, Md. DATE SIGNED 5/31/51			
23. BURIAL/CREMATION REMOVAL (Specify) Burial		DATE THEREOF June 2/51	NAME OF CEMETERY OR CREMATORIAL Elkton Cemetery
LOCATION (City, town, or county) (State)		Elkton Md.	
DATE REC'D BY LOCAL REG. June 2		REGISTRAR'S SIGNATURE H. W. Pippin	24. FUNERAL DIRECTOR ADDRESS H. W. Pippin & Son Elkton, Md.

BUREAU
N.Y.C.

REG/

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04770

CERTIFICATE OF DEATH

Reg. Dist. No. 91

1. PLACE OF DEATH COUNTY <i>Cecil</i>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Md</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Rural - Chesapeake City</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Rural - Chesapeake City</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR give nearest town)		LENGTH OF STAY (in this place)		STREET ADDRESS		(If rural, give location)			
TOWN <i>Rural - Chesapeake City</i>		years							
HOSPITAL OR INSTITUTION OR STREET ADDRESS									
3. NAME OF DECEASED (Type or Print)		(First) <i>Pauline</i>	(Middle)	(Last) <i>BARAHURA</i>	4. DATE OF DEATH	(Month) <i>May</i>	(Day) <i>18</i>	(Year) <i>1951</i>	
5. SEX <i>F</i>		6. COLOR OR RACE <i>Wh.</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>		8. DATE OF BIRTH <i>Oct 27, 1885</i>		9. AGE last birthday If under 1 year Months Days Hours Min. <i>65 yrs. 6</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		11. BIRTHPLACE (State or foreign country) <i>Austria</i>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>Philip Trush</i>		14. MOTHER'S MAIDEN NAME <i>No Information</i>		15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>260X</i>		16. SOCIAL SECURITY NO. <i>61</i>		17. INFORMANT AND ADDRESS <i>Andrew Barahura</i>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause
Meningitis

(a)

Antecedent cause(s)
Diabetes mellitus

(b)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last
61

(c)

INTERVAL BETWEEN
ONSET AND DEATH*3 days**10 years*II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION

19h. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No

21. ACCIDENT SUICIDE HOMICIDE <i>61</i>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <i>INJURY</i>		(CITY OR TOWN)		(COUNTY)		(STATE)	
TIME (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at m. Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
OF INJURY									

22. I hereby certify that I attended the deceased from *June 1948*, to *May 18, 1951*, that I last saw the deceasedalive on *May 17, 1951*, and that death occurred at *7:05 A.M.* from the causes and on the date stated above.SIGNATURE
Ben Thorne(Degree or title)
*M.D.*ADDRESS
*Chesapeake City*DATE SIGNED
May 19/51

23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE <i>May 21, 1951</i>	NAME OF CEMETERY OR CREMATORIUM <i>St. Rose</i>		LOCATION (City, town, or county) <i>Chesapeake City</i>		(State) <i>Md.</i>	
DATE REC'D BY LOCAL REG. <i>May 20-1951</i>		REGISTRAR'S SIGNATURE <i>Mrs. Pauline D. M. N. Pippin</i>	24. FUNERAL DIRECTOR ADDRESS <i>Einton, Md.</i>					



MARGIN RESERVED FOR BINDING

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MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

04771

Reg. Dist. No. 92

1. PLACE OF DEATH: COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)		(First)	(Middle)
4. DATE OF DEATH		(Last)	(Month)
5. SEX		6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT		18. MEDICAL CERTIFICATION	
19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>Leerbral Accident</i>			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) OF INJURY	(Day) (Year) m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> . SIGNATURE <i>Dr. W. E. B. Dodson, M.D.</i> ADDRESS <i>Providence, R.I.</i> DATE SIGNED <i>5/16/51</i>			
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>5/19/51</i>	NAME OF CEMETERY OR CREMATORIAL <i>Providence Cem.</i> LOCATION (City, town, or county) <i>Elkton, Maryland</i> (State)
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE <i>H. R. Frazer</i>	24. FUNERAL DIRECTOR ADDRESS <i>John R. Bell</i> 909 Poplar St.	



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MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

04772

Reg. Dist. No.

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE		
<i>Berl</i> CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)		
OR TOWN		STREET ADDRESS		
HOSPITAL OR INSTITUTION OR STREET ADDRESS		(If rural, give location)		
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH		
(First) <i>James</i>		(Month) <i>5</i>		
(Middle) <i>Clayton</i>		(Day) <i>3</i>		
(Last) <i>Bengardner</i>		(Year) <i>1951</i>		
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (S.D.C.)	8. DATE OF BIRTH	
<i>M.</i>	<i>White</i>	<i>Divorced</i>	<i>Oct. 23, 1913</i>	
9. AGE last birthday yrs.	10. BIRTHPLACE (State or foreign country)	11. CITIZEN OF WHAT COUNTRY?		
<i>37</i>	<i>Crumpler N.C.</i>	<i>U. S.</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY?		
<i>Driver & Doctor</i>	<i>State Prop.</i>	<i>U. S.</i>		
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME			
<i>Charles Bengardner</i>	<i>Cora Taylor</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT		
<i>—</i>	<i>229-01-0683</i>	<i>Charles Bengardner 234 S. Third St.</i>		
18. MEDICAL CERTIFICATION				
19. I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause (a) <i>Acute Coronary disease</i> Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) 120.1 94a 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION				
20. AUTOPSY?				
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> OF CAUSE OF DEATH. INJURY	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while work <input type="checkbox"/>	HOW DID INJURY OCCUR?		
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .				
SIGNATURE <i>John D. Jackson M.D. M.E.</i>	(Degree or title) <i>John D. Jackson M.D. M.E.</i>	ADDRESS <i>1111 21st Street, N.W., Washington, D.C.</i>	DATE SIGNED <i>5-8-87</i>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county)	(State)
<i>Burial</i>	<i>May 5, 1951</i>	<i>Chestnut Hill Cemetery, Crumpler N.C.</i>	<i>Crump</i>	<i>N.C.</i>
DATE REC'D BY LOCAL REG. #	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR		
<i>May 3-1951</i>	<i>John D. Jackson</i>	<i>J. E. Tyson</i>		
			ADDRESS	<i>Rising Sun, Md.</i>

RECEIVED

MAY 4 1951

U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 96

04773

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and LENGTH OF STAY OR give nearest town) Port Deposit, Rural (in this place) TOWN Port Deposit, Rural		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Port Deposit, Rural	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) Am os	(Middle) Mitchener	(Last) Burlin
4. DATE OF DEATH	(Month) 5-27-1951	(Day) 19	(Year)
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH
Male	White	7-18-1876	9. AGE last birthday 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Locomotive Engineer		10b. KIND OF BUSINESS OR INDUSTRY P R R	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William J. Burlin		14. MOTHER'S MAIDEN NAME Katherine Hall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 717-07-6055	
17. INFORMANT AND ADDRESS Eva M. Burlin, Port Deposit, Md. R D		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <i>15 month</i>	
177X Immediate cause Carcinoma of Prostate		<i>6 month</i>	
Antecedent cause(s) Disease or conditions, if any, (b)... giving rise to the above cause stating the underlying cause last 51 b			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb. 19, 1951, to May 27, 1951 , that I last saw the deceased alive on May 27, 1951 , and that death occurred at 8:52 a.m. from the causes and on the date stated above. SIGNATURE <i>Clarence J. Benson, M.D.</i> ADDRESS <i>Port Deposit, Md.</i> DATE SIGNED <i>5/28/51</i>			
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF 5-30-1951 NAME OF CEMETERY OR CREMATORIAL Hopewell LOCATION (City, town, or county) Port Deposit, Md. (State) Rural	
DATE REC'D BY LOCAL REG. May 30, 1951		REGISTRAR'S SIGNATURE <i>Ida M. Daugherty</i> FUNERAL DIRECTOR <i>Lewa Patterson & Son</i> ADDRESS <i>Perryville, Md.</i>	
24. FUNERAL DIRECTOR ADDRESS			

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04774

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
Thomas M. Calvert		May 26, 1957	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
Male	White	Married	Sept. 26, 1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Banker		Over-House	Md.
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
William Calvert		Mary Ellen Boyd	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
No		17. INFORMANT AND ADDRESS	
18. MEDICAL CERTIFICATION			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN
ONSET AND DEATH

260X Immediate cause (a) Diabetic coma 1 day

61 Antecedent cause(s) (b) Cordis renal vascular

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not
related to the disease or condition causing death.

20. AUTOPSY?

Yes No

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)	
INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>				
TIME (Month)	(Day)	(Year)	(Hour)	HOW DID INJURY OCCUR?		
OF INJURY	m.					

22. I hereby certify that I attended the deceased from 5/24, 1957, to 5/26, 1957, that I last saw the deceased alive on 5/26, 1957, and that death occurred at 4:25 P.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county)	(State)
May 29, 1957	Presbyterian	Chesapeake	Chesapeake	Md.
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
May 28	Elmer Frager	Herbert Bates	Perry Point, Perry Point, Md.	

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04775

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE	
Cecil MARYLAND		Maryland	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
Perry Point 23 days		Huntingtown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
Veterans Administration Hospital		(If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) JAMES	(Middle)	(Last) CHEW
4. DATE OF DEATH	(Month) May	(Day) 26	(Year) 1951
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH
Male	Negro	Married	5-12-1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farming	Self employed	Prince Frederick Co., Md.	USA
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Perry Chew	Martha Chew (Maiden Name unknown)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS	
Yes	None	Hospital Records, VAH, Perry Point, Md.	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) Peritonitis, diffuse due to Antecedent cause(s) (b) Intestinal obstruction Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Carcinoma of rectum due to			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)
INJURY		(CITY OR TOWN)	
TIME (Month) (Day) (Year)	(Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
OF INJURY	—	m.	
22. I hereby certify that I attended the deceased from May 3, 1951, to May 26, 1951, that I last saw the deceased at 8:00 P.m., from the causes and on the date stated above.			
SIGNATURE W. Oppen, M.D., Acting Chief, Professional Services, VAH, Perry Point, Md.		ADDRESS	
DATE SIGNED 5-28-51			
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county)
Removal	5-28-51	Unknown	(State)
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	
May 28, 1951	Ida M. Daugherty	ADDRESS	
PENNINGTON & SON, Havre de Grace, Md.			

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

04776

Reg. Dist. No. 92

1. PLACE OF DEATH COUNTY <i>Cecil</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Pa.</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <i>Elkton</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Philadelphia</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Elkton Hospital</i>		STREET <i>1950 S. Bonnall</i>	
3. NAME OF DECEASED (Type or Print) <i>CHARLES Edward Clark.</i>		4. DATE OF DEATH <i>5 19 1951</i>	
5. SEX <i>M. M.</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>10-6-1927</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Sgt Marine Corp. Marine Corp.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Penn. Pa.</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.</i>	
13. FATHER'S NAME <i>Merle Clark.</i>		14. MOTHER'S MAIDEN NAME <i>Born.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>178-20-7303</i>	
17. INFORMANT <i>Florence Garemor.</i>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause *Compound fracture of skull*INTERVAL BETWEEN
ONSET AND DEATHAntecedent cause(s) *with loss of brain tissue*

Diseases or conditions, if any, giving rise to the above cause

stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION *19b. MAJOR FINDINGS OF OPERATION*

20. AUTOPSY?

Yes No

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office building, etc.) <i>Elkton 40</i>	(CITY OR TOWN) <i>Elkton</i>	(COUNTY) <i>Rural Cecil Md.</i>	(STATE) <i>Md.</i>	
TIME (Month) (Day) (Year) <i>5 19 61</i>	INJURY OCCURRED OF (Hour) <i>3:25 p.m.</i>	HOW DID INJURY OCCUR? While at work <input type="checkbox"/> Not while work <input type="checkbox"/> at work <input type="checkbox"/>	<i>Car turned over thru kindest</i>		

22. I certify that I took charge of the remains described above, held an Autopsy , Inspection Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes accident suicide homicide undetermined .

SIGNATURE *Re Dockson M.D. D.M.E.*(Degree or title) *Resident*ADDRESS *Reservoir Md.*DATE SIGNED *07/19/51*

23. BURIAL, CREMATION REMOVAL (Specify) <i>Removal</i>	DATE THEREOF <i>5/20/1951</i>	NAME OF CEMETERY OR CREMATORIAL REG. <i>Reg. No.</i>	LOCATION (City, town, or county) <i>Quantico, Va.</i>	(State) <i>Va.</i>
DATE REC'D BY LOCAL REG. <i>May 20</i>	REGISTRA'S SIGNATURE <i>H. H. Frazer</i>	24. FUNERAL DIRECTOR <i>H. W. Pippin & Son</i>		



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04777

Reg. Dist. No. 96

CERTIFICATE OF DEATH

The correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. It is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY		Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE District of Columbia COUNTY	
CITY (If outside corporate limits, write RURAL and OR, give nearest town) TOWN		LENGTH OF STAY (in this place) 25 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Veterans Administration Hospital		STREET ADDRESS (If rural, give location) 1330 N. Capitol Street	
3. NAME OF DECEASED (Type or Print)	(First) WILLIAM	(Middle) O.	(Last) COUSINS	4. DATE OF DEATH	(Month) May (Day) 4 (Year) 1951
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months Days Hours Mins.
Male	Negro	5-28-1890	60 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Messenger		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
William Cousins - Deceased		Sarah Harris - Deceased			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS	
I W T		Unknown		Hospital Records, VAH, Perry Point, Md.	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
<p>194X 55c</p> <p>Immediate cause (a) Carcinoma of thyroid with localized and generalized metastasis</p> <p>Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last</p> <p>(c)</p>					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work m.	Not While At work	HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from April 9, 1951, to May 4, 1951, that I last saw the deceased May 4, 1951, and that death occurred at 10:00 a.m., from the causes and on the date stated above.					
SIGNATURE		(Degree or title)		ADDRESS DATE SIGNED	
E.P. BRANNON, M.D. Chief, Professional Services, VAH, Perry Point, Md. 5-7-51					
23. BURIAL, CREMATION REMOVAL (Specify) Removal		DATE THEREOF 5-7-51		NAME OF CEMETERY OR CREMATORIAL Arlington National	
DATE REC'D BY LOCAL REG. May 7 1951		REGISTRAR'S SIGNATURE See Dr. Dougality		LOCATION (City, town, or county) Arlington, Va.	
24. FUNERAL DIRECTOR				ADDRESS Pennington & Son, Havre de Grace, Md.	

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MAY 9 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04778

CERTIFICATE OF DEATH

Reg. Dist. No. 91

1. PLACE OF DEATH CITY TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (in this place)		2. USUAL RESIDENCE (HOME) OF DECEASED STATE CITY TOWN STREET ADDRESS	
Cecil		Werwick 1 yr.		Md. Cecil Werwick Water street, Elsie Turner's Res.	
3. NAME OF DECEASED (Type or Print)	(First) Steven	(Middle)	(Last) Davis	4. DATE OF DEATH	(Month) 5 (Day) 8 (Year) 1957
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed	8. DATE OF BIRTH Oct 10 1892	9. AGE last birthday 58 yrs.	If under 1 year Months Days Hours If under 24 hrs. Days Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown.	17. INFORMANT Elsie Davis.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	18. MEDICAL CERTIFICATION Heart Failure 2 days 24 hours		

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) congestive Heart Failure 2 days 24 hours			
420.1 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause 93d stating the underlying cause last			
(b) coronary occlusion.			
(c) Arteriosclerosis.			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)
TIME (Month) (Day) (Year)	(Hour)	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	(CITY OR TOWN)
OF INJURY	m.	HOW DID INJURY OCCUR?	(CITY OR TOWN)

22. I hereby certify that I attended the deceased from May 8, 1951, to May 8, 1951, that I last saw the deceased alive on May 9, 1951, and that death occurred at 7:25 P.M., from the causes and on the date stated above.

SIGNATURE was a/s/o seen by Dr. Lee Middlecamp, M.D.	(Degree or title) Oberhaein M.D.	ADDRESS Cecilton, Md.	DATE SIGNED May 9 1951
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF May 12-1951	NAME OF CEMETERY OR CREMATORIAL Cecilton	LOCATION (City, town, or county) (State) Cecilton Md
DATE REC'D BY LOCAL REG. May 11-1951	REGISTRAR'S SIGNATURE Mrs Harold Cheyney	24. FUNERAL DIRECTOR Dr. Harold Cheyney	ADDRESS 880105

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BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04779

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH- COUNTY <i>Cecil</i>		2. USUAL RESIDENCE (HOME) OF DECEASED- CITY <i>Chesapeake City</i> COUNTY <i>Chesapeake City</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i>		LENGTH OF STAY (in this place) <i>10 days</i>	
TOWN <i>Elkton</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Chesapeake City</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Union Hospital</i>		STREET ADDRESS <i>101 Union Street</i>	

3. NAME OF DECEASED (Type or Print) <i>WALTER</i>	(First) <i>W</i>	(Middle) <i>R</i>	(Last) <i>Douglas</i>	4. DATE OF DEATH <i>May 18</i>	(Month) <i>May</i>	(Day) <i>18</i>	(Year) <i>1951</i>
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5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Nov. 12, 1880</i>	9. AGE last birthday <i>71</i>	If under 1 year Months. <i>0</i>	If under 24 hrs. Days <i>0</i>	If under 1 min. Hours <i>0</i>	Min. <i>0</i>
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10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bookkeeper</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Bookkeeper</i>	11. BIRTHPLACE (State or foreign country) <i>Chesapeake City, Md.</i>	12. CITIZEN OF WHAT COUNTRY <i>US</i>
--	--	---	--

13. FATHER'S NAME <i>James Douglas</i>	14. MOTHER'S MAIDEN NAME <i>Jessie Daily</i>
--	--

15. WAS DECREASER EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>2633 E Chestfield St</i>	17. INFORMANT AND ADDRESS <i>James Douglas</i>
---	---	--

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		<i>2 months</i>
Immediate cause <i>581.1</i>	(a) <i>Cirrhosis of Liver</i>	
Antecedent cause(s) <i>124a</i>	(b) <i>Chronic alcoholism</i>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	<i>3 years</i>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) <i>Chesapeake City</i> (COUNTY) <i>Chesapeake City</i> (STATE) <i>MD</i>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at m. Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <i>March 31, 1951</i> , to <i>May 18, 1951</i> , that I last saw the deceased alive on <i>May 1, 1951</i> , and that death occurred at <i>8:15 A.M.</i> from the causes and on the date stated above.
SIGNATURE <i>James Douglas</i> (Degree or title) <i>M.D.</i> ADDRESS <i>Chesapeake City</i> DATE SIGNED <i>5/18/51</i>

23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>	DATE <i>May 22, 1951</i>	NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Cherry Hill Park (Burial grounds) Cherry Hill Md</i>	LOCATION (City, town, or county) <i>Cherry Hill Md</i> (State) <i>MD</i>
DATE REC'D BY LOCAL REG. <i>May 22</i>	REGISTRAR'S SIGNATURE <i>J. H. Frayzel</i>	24. FUNERAL DIRECTOR ADDRESS <i>Hartman & Son Elkton Md</i>	

RECEIVED
MAY 24 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04780

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH COUNTY <i>Cecil</i>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Pa</i>		COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Elkton</i>		LENGTH OF STAY (in this place) <i>2 3 days</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Altoona</i>		(If rural, give location) <i>1515 22d Ave</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Union Hospital</i>				STREET ADDRESS			
3. NAME OF DECEASED (Type or Print) <i>Ernest</i>		(First) <i>E</i> (Middle) <i>W</i> (Last) <i>Fleck</i>		4. DATE OF DEATH <i>5 6 1951</i>		(Month) (Day) (Year)	
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>married</i>		8. DATE OF BIRTH <i>Jan 24, 1898</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House info</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>At Home</i>		9. AGE last birthday <i>53</i>		If under 1 year Months <i>3</i> Days <i>3</i> Hours <i>10</i> Min. <i>10</i>	
13. FATHER'S NAME <i>Christian Feltman</i>		14. MOTHER'S MAIDEN NAME <i>Anna Marie Mair</i>		11. BIRTHPLACE (State or foreign country) <i>Altoona</i>		12. CITIZEN OF WHAT COUNTRY <i>Pa. U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>123-45-6789</i>		17. INFORMANT AND ADDRESS <i>Albert L. Fleck.</i>			

18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause <i>Cancer of Breast</i>		(a) <i>Cervical Fibrosis</i>		INTERVAL BETWEEN ONSET AND DEATH <i>14 hours</i>			
170X Antecedent cause(s) <i>50</i>		(b) <i>Pulmonary Embolus</i>		INTERVAL BETWEEN ONSET AND DEATH <i>14 hours</i>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		<i>Malignant Car to Lung from Breast</i>					
(c) <i>to Plasma & Mediastinum.</i>							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION <i>April - 1948</i>		19b. MAJOR FINDINGS OF OPERATION <i>Carcinoma of Breast</i>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at m. Work <input type="checkbox"/> At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from *Jan. 1, 1951*, to *May 6, 1951*, that I last saw the deceased alive on *May 6, 1951*, and that death occurred at *4:30 P.m.*, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE <i>5-6-51</i>		NAME OF CEMETERY OR CREMATORIAL <i>Oxford Farms</i>		LOCATION (City, town, or county) (State) <i>Altoona Pa.</i>	
DATE REC'D BY LOCAL REG. <i>May 6</i>		REGISTRAR'S SIGNATURE <i>J. W. Steager</i>		24. FUNERAL DIRECTOR <i>H. W. Pippin & Son</i>		ADDRESS <i>Elkton Md.</i>	



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04781

Reg. Dist. No. 96

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE	
Cecil MARYLAND		District of Columbia	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
Perry Point 21 days		Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
Veterans Administration Hospital		(If rural, give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
(First) ALONZO (Middle) (Last) GREEN		OF DEATH May 23 1951	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Male	Negro	Widowed	8-16-1892
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Green - Deceased		14. MOTHER'S MAIDEN NAME Emma Warren - Deceased	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. None	
17. INFORMANT AND ADDRESS Hospital Records, VAH, Perry Point, Md.		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<p>179X Immediate cause (a) Pneumonia, bronchial, bilateral 51d Antecedent cause(s) due to Diseases or conditions, if any, (b) Carcinoma, squamous, cell type, of the penis, giving rise to the above cause with metastasis stating the underlying cause last (c)</p>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	
OF INJURY		HOW DID INJURY OCCUR?	
m.			
VA			
22. I hereby certify that I attended the deceased from May 2, 1951, to May 23, 1951, that I saw the deceased alive on May 2, 1951, and that death occurred at 9:40 a.m., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED			
E. P. BRANNON, M.D. Chief, Professional Services, VAH, Perry Point, Md. 5-24-51			
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State)	
Removal		5-24-51 Arlington National Arlington, Va.	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE	
May 24-51		John. Longhurt	
act Reg.		24. FUNERAL DIRECTOR ADDRESS	
		BARNES & MATTHEWS, 614-4th St. S.W. Wash. D.C.	



BUREAU OF INVESTIGATION

MAY 28 1954

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

114782

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH COUNTY <i>Baltimore - Elkton</i>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Salisbury, Md. Maryland</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Elkton -</i>		LENGTH OF STAY (in this place) <i>17 days</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Salem</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Union Hospital</i>		STREET ADDRESS <i>Rd.</i>		(If rural, give location) <i>Rd.</i>	
3. NAME OF DECEASED (Type or Print) <i>George</i>		(First) <i>George</i> (Middle) <i>?</i> (Last) <i>Greco</i>	4. DATE OF DEATH <i>May 3rd 1951</i>		(Month) <i>May</i> (Day) <i>3rd</i> (Year) <i>1951</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>Divorced</i>	8. DATE OF BIRTH <i>Aug 3-1903</i>	9. AGE last birthday <i>67</i>	10. under 1 year 11. Months. <i>May</i> 12. under 24 hours Hours <i>28</i> Min. <i>00</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>At home</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home wife</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>None</i>	
13. FATHER'S NAME <i>George Washburn</i>		14. MOTHER'S MAIDEN NAME <i>No information</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>	
16. SOCIAL SECURITY NO. <i>500 Clamer St. 2d</i>		17. INFORMANT AND ADDRESS <i>Betty Jackson Richardson Park</i>		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <i>19</i>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) *Cerebral hemorrhage*

331X

Antecedent cause(s)

(b) *Hypertension*

83a

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
--	---	----------------	----------	---------

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at m. Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
--	--	-----------------------

22. I hereby certify that I attended the deceased from *Apr. 13, 1951* to *May 2, 1951*, that I last saw the deceasedalive on *May 1st, 1951*, and that death occurred at *May 2, 1951 a.m.* from the causes and on the date stated above.

SIGNATURE

(Degree or title) ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL, (Specify) <i>Burial</i>	DATE <i>May 3-1951</i>	NAME OF CEMETERY OR CREMATORIAL <i>Washburn Burial Ground Salisbury</i>	LOCATION (City, town, or county) <i>Salisbury</i>	(State) <i>Md.</i>
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DATE REC'D BY LOCAL REG. <i>May 2</i>	REGISTRAR'S SIGNATURE <i>H. H. Frazer</i>	24. FUNERAL DIRECTOR <i>H. W. Pippin & Son</i>	ADDRESS <i>Elkton Md.</i>
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RECEIVED
MAY 4 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04783

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE District of Columbia COUNTY	
Cecil MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Perry Point	
LENGTH OF STAY (in this place) 1 mo.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Washington	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		STREET ADDRESS 2138 N. Street, N.W. (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) LONNIE	(Middle)	(Last) HOUGH
4. DATE OF DEATH	(Month) May	(Day) 3	(Year) 1951
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 4-29-1890
9. AGE last birthday If under 1 year Months 61 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor	11. BIRTHPLACE (State or foreign country) South Carolina	12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME Jim Hough - Deceased	14. MOTHER'S MAIDEN NAME No Record	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war, or dates of service) Yes WW I	
16. SOCIAL SECURITY NO. Unknown	17. INFORMANT AND ADDRESS Hospital Records, VAH, Perry Point, Md.	18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
151X Immediate cause Carcinoma of stomach with generalized metastasis to peritoneal cavity and chest organs			
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause 468 stating the underlying cause last			
(a) 468 (b) stating the underlying cause last			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
(CITY OR TOWN)		(CITY OR TOWN)	(CITY OR TOWN)
(COUNTY)		(COUNTY)	(COUNTY)
(STATE)		(STATE)	(STATE)

22. I hereby certify that I attended the deceased from April 3, 1951, to May 3, 1951, VA met to see the deceased and to see the deceased and that death occurred at 5:45 P.m. , from the causes and on the date stated above.			
SIGNATURE		(Degree or title) ADDRESS DATE SIGNED	
E.P. BRANNON, M.D. Chief Professional Services, VAH, Perry Point, Md. 5-7-51			
23. BURIAL, CREMATION REMOVAL (Specify) Removal	DATE THEREOF 5-7-51	NAME OF CEMETERY OR CREMATORIAL Arlington National	LOCATION (City, town, or county) Arlington, Va. (State)
DATE REC'D BY LOCAL REG. May 7 1951	REGISTRAR'S SIGNATURE John. Doug Hart	24. FUNERAL DIRECTOR Pennington & Son	ADDRESS Havre de Grace, Md.

RECEIVED
MAY 9 1951
BUREAU U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04784

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH. COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) SAMUEL		(Month) May	
(Middle) M.		(Day) 22	
(Last) JAMESON		(Year) 1951	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH
Male	White	Married	11-10-1888
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance Solicitor		10b. KIND OF BUSINESS OR INDUSTRY	
		Broker	
12. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Alphonse Jameson - Deceased		Julia D. Clark - Deceased	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO.	
W.W.I		None	
17. INFORMANT AND ADDRESS		Hospital Records, VAH, Perry Point, Md.	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
355X Immediate cause (a) Pneumonia, bronchial Antecedent cause(s) due to Diseases or conditions, if any, (b) Huntington's Chorea with neurotrophic skin giving rise to the above cause changes and secondary infection stating the underlying cause last 107 (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/> Not While Work <input type="checkbox"/>	
m.		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Oct. 3, 1948, to May 22, 1951, that I last saw the deceased and that death occurred at 8:30 a.m., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED E. P. BRANNON, M.D. Chief Professional Services, VAH, Perry Point, Md. 5-22-51			
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF	
Removal		NAME OF CEMETERY OR CREMATORIAL	
5-22-51		LOCATION (City, town, or county) Fallston, Md.	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE	
May 22, 1951		24. FUNERAL DIRECTOR ADDRESS W. J. Tickner & Sons W. J. Tickner & Sons, North & Pa. Aves. Baltimore, Md.	
act Reg. J			

RECEIVED
MAY 24 1951
RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04785

CERTIFICATE OF DEATH

Reg. Dist. No. 92

1. PLACE OF DEATH COUNTY		Cecil		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE		Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN		STREET ADDRESS	
Elston		Elston		12 days		Elston		Elston		Rural 5	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Union Hospital									
3. NAME OF DECEASED (Type or Print)		(First) MARGARET B.		(Middle)		(Last) JAYNES		4. DATE OF DEATH		(Year) 1951	
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow		8. DATE OF BIRTH		9. AGE last birthday		If under 1 year Months Days Hours Min.	
Female		White		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		12 - 9 - 1870		80 yrs.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT AND ADDRESS		12. CITIZEN OF WHAT COUNTRY	
Joseph Russell		Sarah Jamison		None				Harvey W. Orland Elston Md.		None	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Cerebro-Vascular Accident

INTERVAL BETWEEN
ONSET AND DEATH

12 days

Antecedent cause(s)

(b) Hypertensive Cardio vascular disease

One year

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause lastII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not
related to the disease or condition causing death.

(c) Atrial fibrillation - intermittent

One year

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No

21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY)		(STATE)	
INJURY									
TIME (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED		HOW DID INJURY OCCUR?			
OF INJURY				While at m.	Not While Work	<input type="checkbox"/>	At work	<input type="checkbox"/>	

22. I hereby certify that I attended the deceased from Jan 5, 1951, to May 9, 1951, that I last saw the deceased

alive on May 9, 1951, and that death occurred at 10:50 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED
5/10/51

23. BURIAL, CREMATION REMOVAL (Specify)		DATE		NAME OF CEMETERY OR CREMATORIAL		LOCATION (City, town, or county)		(State)	
Burial		5-13-51		Methodist Cherry Hill		Cherry Hill, Cecil		Md.	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS			
May 12		H. H. Steamer		Joseph R. Steamer		North East Md.			

RECEIVED
MAY 14 1951

BUREAU U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04786
96

CERTIFICATE OF DEATH

Reg. Dist. No.

The correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The causes of death clearly and legibly. is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY Cecil		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Perry Point		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Perry Point	
LENGTH OF STAY (In this place) 7 yrs.		STREET ADDRESS 1154 Ave. A	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		(If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) Sara	(Middle) Davis	(Last) Mc Greevy
4. DATE OF DEATH	5/30/51		
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH Unknown
9. AGE last birthday If under 1 year Months. Days	10. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Scranton, Pa.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME James J. Moran	14. MOTHER'S MAIDEN NAME Sara J. Mc Hale	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT AND ADDRESS Dr. Joan McGreevy, Perry Point, Md.	

18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause 420.0	(a) Congestive Heart Failure	INTERVAL BETWEEN ONSET AND DEATH 2 mo.	
Antecedent cause(s) 93d	(b) Arteriosclerotic heart disease	10 yrs.	
Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last 93d	(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, of office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 19....., to 19....., that I last saw the deceased alive on 19....., and that death occurred at 6:30 A.m., from the causes and on the date stated above.					
SIGNATURE <i>John A. Fischer, M.D.</i>	(Degree or title) <i>Veteran Hospital, Perry Point, Maryland</i>	ADDRESS	DATE SIGNED <i>June 1951</i>		
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 6/2/51	NAME OF CEMETERY OR CREMATORIAL Angel Hill	LOCATION (City, town, or county) Havre de Grace, Md.	(State)	
DATE REC'D BY LOCAL REC'D <i>June 6 1951</i>	REGISTRAR'S SIGNATURE <i>Ida M. Daugherty</i>	24. FUNERAL DIRECTOR ADDRESS <i>Pennington & Son, Havre de Grace, Md.</i>			

REGISTRATION
JUN 4 1951

BUREAU U.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04787

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE	
Cecil MARYLAND		Massachusetts	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Perry Point		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Jamaica Plain	
LENGTH OF STAY (in this place) 8 yr. 26 days		STREET ADDRESS (If rural, give location) 5 Fordham Court	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital			
3. NAME OF DECEASED (Type or Print)	(First) LILLIAN	(Middle) E.	(Last) MC INTYRE
4. DATE OF DEATH	(Month) May	(Day) 22	(Year) 1951
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH
Female	White	10-15-1882	9. AGE last birthday 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Operator		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Massachusetts
			12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I	17. INFORMANT AND ADDRESS Hospital Records, VAH, Perry Point, Md.
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) Hemorrhage, cerebral due to			
33 IX Antecedent cause(s) (b) Arteriosclerosis, cerebral. Arteriosclerosis Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last generalized			
83a (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? Not While <input type="checkbox"/>
22. I hereby certify that I attended the deceased from April 26, 1943, to May 22, 1951, and I declare that the deceased died at Perry Point, Md., and that death occurred at 4:05 a.m., from the causes and on the date stated above. SIGNATURE: <i>E. P. Brannon</i> (Degree or title) ADDRESS DATE SIGNED E. P. BRANNON, M.D. Chief Professional Services, VAH, Perry Point, Md. 5-23-51			
23. BURIAL, CREMATION REMOVAL (Specify) Removal		DATE THEREOF 5-23-51	NAME OF CEMETERY OR CREMATORIAL St. Joseph's
DATE REC'D BY LOCAL REG. May 23, 1951		REGISTRAR'S SIGNATURE <i>John D. Murphy</i>	LOCATION (City, town, or county) Boston, Mass.
24. FUNERAL DIRECTOR ADDRESS			
PENNINGTON & SON, Havre de Grace, Md. 370 WUU			

RECEIVED
MAY 20 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04788

CERTIFICATE OF DEATH

Reg. Dist. No. 96

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH. COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE	
Cecil		Maryland	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN		LENGTH OF STAY (In this place)	
Perryville		20 yrs	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)		(First)	(Middle)
Female		Bu nah	F.
5. SEX		6. COLOR OR RACE	
Female		White	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	
House Wife		Divorced	
13. FATHER'S NAME		8. DATE OF BIRTH	
Crit Flanery		2-14-1907	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		9. AGE last birthday	
No		44 yrs	
16. SOCIAL SECURITY NO.		11. BIRTHPLACE (State or foreign country)	
		Kentucky	
17. INFORMANT AND ADDRESS		12. CITIZEN OF WHAT COUNTRY	
Irene Sanders, Sparta, N. Carolina.		USA	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause 002X		(a) Pulmonary Tuberculosis - 1949	
Antecedent cause(s) 13b		Chronic Myocarditis 1948	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last 13b		(b) (c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY?		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE TIME (Month) (Day) (Year) (Hour) OF INJURY		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
m.		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>May 16, 1951</u> , to <u>May 20, 1951</u> , that I last saw the deceased alive on <u>May 16, 1951</u> , and that death occurred at <u>9:30 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>Elmer J. Johnson</u> ADDRESS <u>1124 Fort Deposit Rd. 5/27/51</u> DATE SIGNED <u>5/27/51</u>			
23. BURIAL, CREMATION REMOVAL (Specify)		DATE	NAME OF CEMETERY OR CREMATORIAL LOCATION (City, town, or county) (State)
Burial		5-31-1951	Principio Furnace, Md.
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
May 31-1951		Ida M. Dougherty	Vera Johnson & Son Perryville, Md.



96

CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

SE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED STATE	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
EDWARD	H		NEVILLE
4. DATE OF DEATH	(Month)	(Day)	(Year)
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWER, DIVORCED, ASOC.	8. DATE OF BIRTH
M	White	MARRIED	3-17-1878
9. AGE last birthday yrs.	10. USUAL OCCUPATION (Give kind of work done during most working life even if retired) Retired man by unknown	11. KIND OF BUSINESS OR INDUSTRY	12. CITIZEN OF WHAT COUNTRY
73			Irish
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME		
Edward Neville	Ellen Howard		
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, <input checked="" type="checkbox"/> No, <input type="checkbox"/> I D K) No	16. SOCIAL SECURITY NO. (If yes, <input type="checkbox"/> I D K) Service	17. INFORMANT	18. MEDICAL CERTIFICATION
Acute Coronary Occlusion			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a)			
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereto and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE Dr. Edward Neville D.M.E.	(Degree or title)	ADDRESS Wellesley, Mass.	DATE SIGNED 5/10/57
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county) Waltham, Mass.
DATE REC'D BY LOCAL REG. May 10, 1957	REG. No. 12345678	REG. No. 12345678	ADDRESS Wellesley & Br. Hanover
REG. No. 12345678		REG. No. 12345678	REG. No. 12345678

RECEIVED
MAY 14 1951

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

04790

Reg. Dist. No. 94

1. PLACE OF DEATH: COUNTY		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE	
CITY (If outside corporate limits, write RURAL and OR give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN		STREET	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		ADDRESS	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) SENA		(Month) 5 (Day) 25 (Year) 1951	
(Middle) W			
(Last) OWENS			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED Specify	8. DATE OF BIRTH
F.	White	MARRIED	6-29-1855
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Housewife		Leppington	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
Calvert County		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Milton White		Martha Colwell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
(If yes, give war or dates of service)		—	
17. INFORMANT			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <i>Senility General Debility</i>		
Antecedent cause(s) (b) <i>Arterio sclerosis.</i>		
Disease or condition, if any, giving rise to the above cause stating the underlying cause last (c) <i>97</i>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?
				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes accident suicide homicide undetermined .

SIGNATURE		(Degree or title)	ADDRESS	DATE SIGNED
<i>Alfred D. D. M. E.</i>			<i>Principia Md.</i>	<i>5/24/51</i>
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL	LOCATION (City, town, or county) (State)
<i>Burial</i>		<i>5-27-51</i>	<i>Principia</i>	<i>Principia Md</i>
DATE REC'D BY LOCAL REG. <i>5-27-51</i>		REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
		<i>Sarah E. Rothermel</i>	<i>Joseph A. Grant</i>	<i>North East, Md</i>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 31 1951
BUREAU Y. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04791

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH. COUNTY		Cecil MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED. STATE Maryland COUNTY Cecil	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		Perry Point LENGTH OF STAY (in this place) 1 Mo. 21 days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Perryville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Veterans Administration Hospital		STREET ADDRESS Front (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) HARRY	(Middle) P.	(Last) PHILLIPS	4. DATE OF DEATH	(Month) May (Day) 2 (Year) 19 51
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year Months 8 Days 14 Hours 11 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? USA
Laborer		New York		
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Elmer Phillips - Deceased		Ella Brooks - Deceased			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS		
WW-1		Unknown	Hospital Records, VAH, Perry Point, Md.		
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
1998 Immediate cause (a) Pneumonia, bronchial due to					
55y Antecedent cause(s) (b) Carcinoma, metastatic, generalized, primary Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last site unknown					
(c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED White at Not White m. Work At work		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb. 12, 1951, to May 2, 1951, and last saw the deceased and that death occurred at 6:10 P.m., from the causes and on the date stated above.					
SIGNATURE E. P. BRANNON		(Degree or title) M.D. Chief, Professional Services, VAH, Perry Point, Md.		DATE SIGNED 5-3-51	
23. BURIAL, CREMATION REMOVAL (Specify) Removal		DATE THEREOF	NAME OF CEMETERY OR CREMATORIAL Mt. Erin	LOCATION (City, town, or county) Havre de Grace, Md.	(State)
DATE REC'D BY LOCAL REG. May 3, 1951		REGISTRAR'S SIGNATURE H. M. Dangbasty	24. FUNERAL DIRECTOR Pennington & Son	ADDRESS 970444	
act Reg. PENNINGTON & SON, Havre de Grace, Md.					

REC'D
MAY 8 1951
FBI - BUREAU V. S.

REF ID: A65420
MAY 14 1951
FBI - BUREAU OF INVESTIGATION

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

04793

Reg. Dist. No.

1. PLACE OF DEATH- CITY Cecil			2. USUAL RESIDENCE (HOME) OF DECEASED- CITY MARYLAND		
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN			LENGTH OF STAY (In this place)		
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spaghetti House, Elkton, Md.			STREET ADDRESS Rronounced dead		
3. NAME OF DECEASED (Type or Print) Baby	(First)	(Middle)	(Last)	4. DATE OF DEATH Rowe	(Month) May (Day) 31, 1951 (Year)
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Single	8. DATE OF BIRTH	9. AGE last birthday yrs. 1	If under 1 year Months 2 Days Hours 2 Min. 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY UNKNOWN	11. BIRTHPLACE (State or foreign country) UNKNOWN	12. CITIZEN OF WHAT COUNTRY? Md.
13. FATHER'S NAME UNKNOWN			14. MOTHER'S MAIDEN NAME Pauline Rowe		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT Pauline Rowe					

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN
ONSET AND DEATHImmediate cause
983X(a) **Comminuted fracture of skull with subdural
and subarachnoid hemorrhage.**

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last
165

(b)

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes No 2t. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.PLACE (Home, farm, factory, street,
OF office building, etc.)
INJURY Home

(CITY OR TOWN)

(COUNTY) (STATE)

Spaghetti House, Rt. 40, Elkton, Md.TIME (Month) (Day) (Year) (Hour)
OF INJURY **5-30-51 3 A.m.**INJURY OCCURRED
While at work Not while work at work

HOW DID INJURY OCCUR?

of same.

Mother delivered baby and disposed22. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes , accident , suicide , homicide , undetermined .

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

700 Fleet Street**6-4-51**23. FUNERAL, CREMATION
REMOVAL (specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORIAL

LOCATION (City, town, or county)

(State)

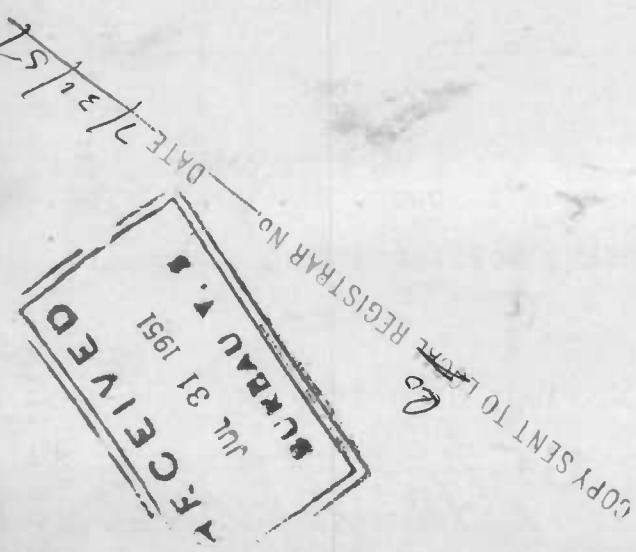
DATE REC'D BY LOCAL
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

7/31/51**a a dedith****Baltimore****Mo****505-11199V99V****Baltimore****Mo**



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

04794

Reg. Dist. No. 92

1. PLACE OF DEATH: COUNTY <i>Elkton</i>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>Md.</i> COUNTY <i>Cecil</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Elkton</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Elkton</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>South Bridge</i>		STREET ADDRESS <i>524 South St.</i>	
3. NAME OF DECEASED (Type or Print) <i>John McAllister Sentman</i>	(First) <i>John</i> (Middle) <i>McAllister</i> (Last) <i>Sentman</i>	4. DATE OF DEATH <i>3-4-1892</i>	(Month) <i>3</i> (Day) <i>4</i> (Year) <i>1892</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>3-4-1892</i>
10a. USUAL OCCUPATION (Give kind of work done during most working life, even if retired) <i>Bar Distiller Beer Bus.</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Bar Distiller Beer Bus.</i>	11. BIRTHPLACE (State or foreign country) <i>Franklin Ind</i>	12. CITIZEN OF WHAT COUNTRY <i>USA</i>
13. FATHER'S NAME <i>Keel Sentman</i>	14. MOTHER'S MAIDEN NAME <i>Mary Mote</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i>218-03-2771</i>		17. INFORMANT <i>Katharine Sentman</i>	18. MEDICAL CERTIFICATION <i>Strangulation by hanging</i>
19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 974X Immediate cause Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>164a</i>			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?	
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, of office, etc.) <i>Office</i> (CITY OR TOWN) <i>Elkton</i> (COUNTY) <i>Cecil</i> (STATE) <i>Ind.</i>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>3-4-1892</i> <i>8:30</i>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR? <i>Hung himself in store room</i>			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input type="checkbox"/> , suicide <input checked="" type="checkbox"/> homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <i>Dr. Ned D. D. D. M. E. D. C. M. D. 5-6-61</i>		(Degree or title) <i>Dr. Ned D. D. M. E. D. C. M. D. 5-6-61</i>	DATE SIGNED <i>5-6-61</i>
23. BURIAL, CREMATION REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>5-8-1951</i>	NAME OF CEMETERY OR CREMATORIAL <i>Gilpin Manor Mem. Park</i> LOCATION (City, town, or county) <i>Elkton, Md.</i> (State) <i>Rural</i>
DATE REC'D BY LOCAL REG. <i>May 7</i>		REGISTRAR'S SIGNATURE <i>E. H. Fray</i>	24. FUNERAL DIRECTOR <i>Lewis Patterson & Son</i> ADDRESS <i>Perryville, Md.</i>

RECEIVED
MAY 9 1954

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04795

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH COUNTY CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN		2. USUAL RESIDENCE (HOME) OF DECEASED STATE District of Columbia CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans' Administration		STREET ADDRESS 314 - 9th Street, N.W.	
3. NAME OF DECEASED (First) (Type or Print) TONY		4. DATE OF DEATH SGRO May 17 1951	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 2-16-1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY Unknown	9. AGE last birthday 57 yrs.
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. None	17. INFORMANT AND ADDRESS Hospital Records, VAH, Perry Point, Md.
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<p>Immediate cause (a) Pneumonia, bilateral</p> <p>420.1 Antecedent cause(s) (b) Coronary sclerosis. Arteriosclerosis</p> <p>94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)</p> <p>generalized</p>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> At work <input type="checkbox"/> Not While <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Nov. 21, 1947, to May 17, 1951, that I last saw the deceased and that death occurred at 6:25 a.m., from the causes and on the date stated above. SIGNATURE (Degree or title) ADDRESS DATE SIGNED E.P. BRANNON, M.D. Chief, Professional Services, VAH, Perry Point, Md. 5-18-51			
23. BURIAL, CREMATION REMOVAL (Specify) Removal		DATE THEREOF 5-19-51	
NAME OF CEMETERY OR CREMATORIAL Arlington National		LOCATION (City, town, or county) Arlington, Va. (State)	
DATE REC'D BY LOCAL REG. May 19 1951		REGISTRAR'S SIGNATURE John M. Douglasty	
		24. FUNERAL DIRECTOR ADDRESS PENNINGTON & SON, Havre de Grace, Md.	



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04796

Reg. Dist. No. 42

CERTIFICATE OF DEATH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY <i>Cecil</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Md</i>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <i>E. Elston</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>E. Elston Rd.</i>	
LENGTH OF STAY (in this place) <i>6 days</i>		STREET ADDRESS <i>(If rural, give location)</i>	
3. NAME OF DECEASED (Type or Print) <i>James E. Stanton Jr.</i>		4. DATE OF DEATH <i>5 6 1951</i>	
(First) <i>James</i>		(Month) <i>5</i>	
(Middle) <i>E.</i>		(Day) <i>6</i>	
(Last) <i>STANTON Jr.</i>		(Year) <i>1951</i>	
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Single</i>		8. DATE OF BIRTH <i>12-8-49</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i>		9. AGE last birthday <i>1 yr.</i>	
10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>		If under 1 year Months. <i>1</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
11. BIRTHPLACE (State or foreign country) <i>Elkton</i>		12. CITIZEN OF WHAT COUNTRY <i>Md USA</i>	
13. FATHER'S NAME <i>James E. Stanton Sr.</i>		14. MOTHER'S MAIDEN NAME <i>Dorothy Edwards</i>	
15. Was DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>340.3</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT AND ADDRESS <i>James E. Stanton Elston Md.</i>		18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause <i>Meningitis</i> , Not considered to be tubercular (a) <i>(5/16/51 a/c)</i>			
Antecedent cause(s) <i>340.3</i>			
Diseases or conditions, if any, (b) giving rise to the above cause stating the underlying cause last <i>81a</i>			
Conditions contributing to the death but not related to the disease or condition causing death. (c) <i>Cerebral palsy, spastic</i>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>Since birth</i>		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <i>Cerebral palsy, spastic</i>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) <i>Elston Md</i>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>5-8-51</i>		INJURY OCCURRED While at m. Work <input type="checkbox"/> At work <input type="checkbox"/> HOW DID INJURY OCCUR? Not While <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <i>May 1, 1951</i> , to <i>May 6, 1951</i> , that I last saw the deceased alive on <i>May 6, 1951</i> , and that death occurred at <i>8:00 A.M.</i> from the causes and on the date stated above. SIGNATURE <i>Ralph Andrew Jr.</i> (Degree or title) <i>M.D.</i> ADDRESS <i>Elston Md</i> DATE SIGNED <i>5/6/51</i>			
23. BURIAL, Cremation REMOVAL (Specify) <i>Burial</i>		DATE <i>5-8-51</i> NAME OF CEMETERY OR CREMATORIUM <i>Methodist Cemetery</i> LOCATION (City, town, or county) <i>Elston Md</i> (State) <i>Md</i>	
DATE REC'D BY LOCAL REG. <i>May 7</i>		REGISTRAR'S SIGNATURE <i>R. Traeger</i> 24. FUNERAL DIRECTOR ADDRESS <i>Joseph R. Leach with C. C. Lee</i>	

RECEIVED
MAY 8 1951
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04797

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Ind.</i>		
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <i>Port Deposit</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Port Deposit</i>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Mayfield Nursing Home</i>		STREET ADDRESS <i>(If rural, give location)</i>		
3. NAME OF DECEASED (Type or Print) <i>Laura V. Vannort</i>	(First) <i>Laura</i> (Middle) <i>V.</i> (Last) <i>VANNORT</i>	4. DATE OF DEATH <i>Nov. 22, 1957</i>	(Month) <i>5</i> (Day) <i>10</i> (Year) <i>1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>Single</i>	8. DATE OF BIRTH <i>Nov. 22, 1858</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>10b. None</i>	9. AGE last birthday <i>92</i>	
13. FATHER'S NAME <i>John V. Vannort</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>93d</i>		16. SOCIAL SECURITY NO. <i>16. None</i>	17. INFORMANT AND ADDRESS <i>Miss Lizzie Atkinson, Port Deposit, Md.</i>	
18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause (a) <i>Chronic myocarditis</i> Antecedent cause(s) (b) <i>Hypertension arteriosclerosis</i> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>93d</i>				
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION <i>19a. None</i>	19b. MAJOR FINDINGS OF OPERATION <i>19b. None</i>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21. ACCIDENT SUICIDE HOMICIDE <i>21. None</i>	(Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY <i>21. None</i>	(CITY OR TOWN) <i>21. None</i>	(COUNTY) <i>21. None</i>	(STATE) <i>21. None</i>
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>22. None</i>	INJURY OCCURRED While at m. Work <input type="checkbox"/> At work <input type="checkbox"/> <i>22. None</i>	HOW DID INJURY OCCUR? <i>22. None</i>		
22. I hereby certify that I attended the deceased from <i>4/30</i> , 19 <i>57</i> , to <i>5/10</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>5/10</i> , 19 <i>57</i> , and that death occurred at <i>7 A.m.</i> , from the causes and on the date stated above. SIGNATURE <i>Allen D. Jackson</i> (Degree or title) <i>7 A.m.</i> ADDRESS <i>7 A.m.</i> DATE SIGNED <i>6/12/57</i>				
23. BURIAL, CREMATION REMOVAL (Specify) <i>23. Burial</i>	DATE <i>May 15, 1957</i>	NAME OF CEMETERY OR CREMATORIAL <i>23. Rosewell Cemetery</i>	LOCATION (City, town, or county) <i>23. Port Deposit, Md. Rural</i>	(State) <i>23. None</i>
DATE REC'D BY LOCAL REC'D <i>May 14-17</i>	REGISTRAR'S SIGNATURE <i>24. Amy Washington</i>	24. FUNERAL DIRECTOR <i>24. Lela Patterson, Inc., Perryville</i>	ADDRESS <i>24. Perryville, Md.</i>	

